C+D

WWW.CHEMISTANDDRUGGIST.CO.UK

5 September 2009

1859-2009 Celebrating 150 years in pharmacy

Kills head lice with a 10 minute treatment time

- No Pesticides
- CLINICALLY PROVEN[1]
- Suitable for people with asthma and sensitive skin
- No nasty smells
- No leaving it on overnight
- Works by stripping the louse of the outer coat, causing dehydration, shrinkage and death

comb included

'AS SEEN ON TV'

Full Marks solution

SSL Full Marks is a Trade Mark of the SSL Group

For everything you need to know about head lice visit **headlice.co.uk**

The NEW simplified Full Marks Range comprises of Solution and Combs.

1 Burgess IF, Brown CM, Lee PN, Pharm Jnl 2008, 280, 371-375

C+D

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5 September 2009

1859-2009 Celebrating 150 years in pharmacy

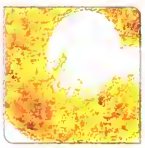
Inspired thinking

Drug developments that changed our lives See page 28

STABBING PAIN

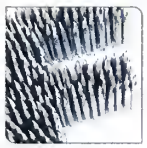
INTRODUCING A PFIZER NEUROPATHIC PAIN PATIENT SYMPTOM AWARENESS PROGRAMME "YOUR MYSTERY PAIN"

Have any of your patients told you that they feel unexplained pain that stabs into them? Chronic pain that is hard to treat can become frustrating. You can aid your patients by asking them to describe their pain, which will help you to identify those with neuropathic pain.

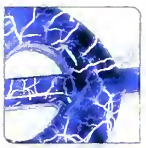


Burning pain

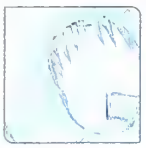
Crawling pain



Stabbing pain



Shocking pain



Freezing pain

Action on pain!

BackCare
The Charity for Healthier Backs

PAIN CONCERN

Trigeminal Neuralgia Association UK

YOUR PATIENTS CAN GET MORE INFORMATION AND SUPPORT BY VISITING

www.nerve-pain.co.uk

TALK TO YOUR PATIENTS ABOUT NEUROPATHIC PAIN AND THE TREATMENTS AVAILABLE

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> CAN YOU REMEMBER THE LAST TIME YOU STOPPED AND TOOK TIME OUT TO RELAX DURING WORK?

Stop. Forget the stack of FP10s just for a second and take part in a little C+D experiment. OK, start off by taking three deep breaths. One. Two. Three. Now, gently rotate your shoulders – making sure you keep sucking in those giant gulps of air – and, while you're doing that, picture the following scene.

You are strolling along the pearl-white sands of a sun-drenched beach. Your favourite cocktail is in your right hand and warm water is rushing up between your toes.

Sorry – end of experiment. You are either feeling very relaxed or possibly very embarrassed, as any colleagues or customers that are watching probably confused your antics with an impression of a giant, floundering carp.

Right, now the method behind this madness. Can you remember the last time you stopped and took time out to relax during work? Chances are that it will have been a long, long time. Six in 10 pharmacists never take a break, according to industry figures.

The Society says this situation must stop, and rightly so (p6). At this week's British Pharmaceutical Conference, the RPSGB will publish twin research papers on the importance of rest breaks. If you are going to Manchester then you may want to look away now. For everyone else, the headline findings are that better workload planning, by companies and staff, can cut work stress. Pharmacists should also be given more time-management training and issued with a firm line on the need to take breaks by employers and their regulator.

But don't hand out the Kit Kats just yet. Although the papers offer a worthy blueprint on work stress, it's largely academia's take on the problem. There are no personal accounts from employed pharmacists on whether they are encouraged to take breaks or not. Feedback from a regional manager or superintendent at one of the national chains is also missing. The lion's share of community pharmacists are now on the payroll at a multiple pharmacy chain so, if the industry is serious about enforcing mandatory rest breaks, the buy in of these big guns is going to be essential.

If we get it, pharmacies could become a much happier place to work. Not many thrive in a heads down environment where you're too afraid to take a break. With three new services possibly making their way into the contract from next April (p6) work demands are only going one way.

Start working smart – planning your work, delegating, getting and giving feedback to/from from your employer – and you'll thrive. Go on thinking lunch is for wimps and burnout might get to you before a new contract appears next spring.

Max Gosney, News Editor

When did you last take a rest break?

mgosney@cmpmedica.com

Services hat-trick on the horizon as PSNC enters contract talks

Moves will help deliver white paper promises, says committee chief executive

Zoe Smeaton
zsmeaton@cmpmedica.com

A national minor ailments scheme and other improved services have moved a step closer after PSNC announced this week that negotiations are underway on a revamped pharmacy contract from April 2010.

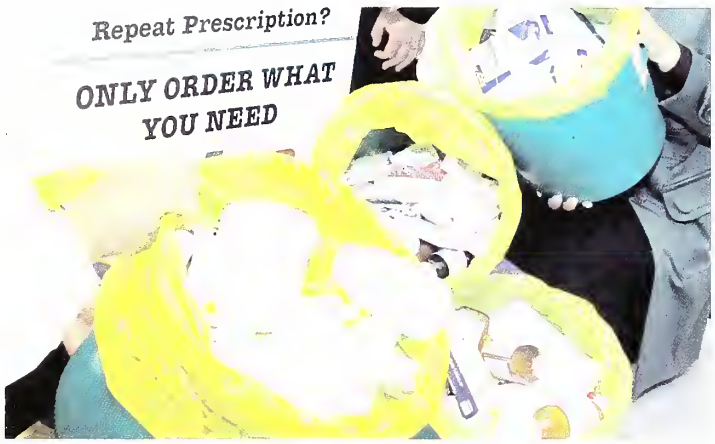
The priorities will be developing services around reducing medicines waste, helping patients with long-term conditions, and extending minor ailments services based on need, the committee said.

PSNC will be holding further discussions with NHS Employers over the coming months.

The committee was unable to comment on how the new services might be funded.

Chief executive Sue Sharpe hailed the discussions as an "exciting opportunity" and the negotiating body said the moves would help develop pharmacy services and deliver the promises outlined in the pharmacy white paper.

It is hoped that the negotiations will be completed this year with implementation of the agreed changes beginning after April 2010.



Reducing medicines waste is one of the service areas under discussion

PSNC said it was unable to comment at this stage on whether any new or improved services might be funded nationally or set up as directed enhanced services.

The committee could also not say whether pharmacists would be able to vote on any contractual changes.

The discussions address a number of areas in the pharmacy white paper on which progress had until now been stalled. A PSNC rolling report on white paper progress recently reported that substantive discussions on incorporating minor ailments schemes into the pharmacy contract had not been held (C+D, August 22, p10).

Mrs Sharpe said the review would be vital in ensuring that the existing pharmacy contract met the needs of the NHS, and that it provided an opportunity to hasten the development of new services.

Industry bodies hire white paper manager

Four pharmacy bodies have appointed a project manager to co-ordinate their work in delivering the white paper.

Rachael Wilkinson, formerly operations manager at the London Dental Hospital, beat three other interviewees to the post last month.

She was chosen by the NPA, CCA, Royal Pharmaceutical Society and AIMp because, said RPSGB director of England Howard Duff: "She's got an understanding of the NHS, project management experience and she has a history of getting things done."

Ms Wilkinson's first priority would be "information gathering" on the four bodies' work on the white paper to date, Mr Duff told C+D.

"The first target is to produce an assessment of the situation, recommendations and timelines for action," he said.

Ms Wilkinson is on an initial six-month contract. She will report into NPA chief executive John Turk. **JR**

Society calls for adequate rest breaks

The RPSGB has called for adequate rest breaks as it ramps up its campaign to reduce pharmacist stress ahead of the British Pharmaceutical Conference (BPC).

Society president Steve Churton said work without breaks was a "key issue" in the sector. He said: "We are asking employers not to allow or encourage pharmacists and pharmacy technicians to work for long periods without breaks."

BPC takes place from September 6 to 9 at Manchester Central.

New pharmacy regulator set to reveal composition of council

The future pharmacy regulator will announce its appointed council members early this month, its chairman has said.

Getting the governing body of the General Pharmaceutical Council (GPhC) "up and running" was Bob Nicholls' first priority following his appointment in June, he told C+D.

The GPhC had "a terrific number" of applications for the remaining 13 places on the council, said Mr Nicholls. Candidates were asked to do a five-minute presentation on the key challenges for the GPhC in its first year. Mr Nicholls said: "We had more candidates that we felt were above the line... than we had places."

The interview panel's recommendations were awaiting approval by the independent Appointments Commission and an announcement would be made in early September, he added.

Bob Nicholls: priority is getting governing body running

The council will get together for the first time at an "education event" in November. Getting the members to "gel" would be a "very important" early part of his role, Mr Nicholls said.

Also in November, steering group PROLOG is expected to formally hand the GPhC over to the new council. However, those appointed will remain council designate only, until their role is formalised by legislation. The target for this was December, although the GPhC is not expected to take over regulation from the RPSGB until April 2010. Interviews for the GPhC chief executive are expected to begin in November. **JR**

Postcode lottery over swine flu vaccine

Lack of guidance has split PCTs over pharmacist vaccinations

Chris Chapman and Andrew Wheeldon
cchapman@cmpmedica.com

Pharmacists in England are trapped in a postcode lottery after Department of Health guidance on swine flu vaccination left PCTs confused over whether the sector is eligible for the jab.

A document leaked to C+D revealed NHS North West Strategic Health Authority (SHA) has advised all PCTs in the region to exclude pharmacists from priority vaccine plans. However, pharmacists will get the jab in other areas, a straw poll of 21 PCTs found.

Last week the DH announced PCTs will decide which pharmacists were eligible for the first round of inoculations, after the sector was excluded from a list of priority health workers in vaccine guide the Green Book.

However, the lack of clear guidance has split PCTs, according to C+D's research.

Pharmacists in the North West of England will miss out on the first wave of the vaccine after the SHA instructed PCTs that pharmacists were not considered "involved in direct patient care".

Pharmacists in North East Essex and Stoke-on-Trent will also miss out in the first round of inoculations after PCTs ruled pharmacists were not included in DH priority groups.

In contrast, pharmacists in Barking and Dagenham and across Hampshire and the Isle of Wight are guaranteed the jab, after health chiefs agreed sector staff were frontline health workers according to the DH guide.

And Birmingham East and North PCT said while it felt the DH list excluded pharmacists, it would still supply the vaccine as the sector was "vital" to health provision.

Great Yarmouth and Waveney PCT head of prescribing Michael Dennis said plans were still being developed "because the guidelines are so unclear", with the PCT "split down the middle" as to whether pharmacists would be included as a priority group.

Yes

Pharmacists will get the vaccine as they are considered vital

Pharmacists are a priority group and will receive the vaccine

All pharmacists and at-risk staff included as a priority group

No

PCTs advised not to include pharmacists as priority group

Pharmacists not in first wave of vaccinations

Pharmacists not a priority, likely to get vaccine later

The answer is...

To celebrate C+D's 150th birthday this September, we look back at the events of 1859

Charles Dickens pens A Tale of Two Cities, which has sold more than 200 million copies worldwide

1859

Vaccine chief denies pharmacist exclusion

The government health chief in charge of vaccination in England has insisted pharmacists should not be automatically excluded from priority lists for the swine flu jab.

Speaking exclusively to C+D, DH director of immunisation Professor David Salisbury said the DH list of priority healthcare workers in vaccine guide the Green Book was not definitive and "did not exclude" pharmacists.

"We can give examples, but it's not for us to give hard and fast rules that won't necessarily apply in all circumstances," he said. "I'm sure there are some pharmacists who have clinical contact that puts them at equal risk with other groups."

The DH had to "trust to the discretion of PCTs" to decide who should be inoculated, Professor Salisbury said. He added that national vaccine plans were still uncertain and would depend on the situation.

"We know exactly how much vaccine will come, per week, and how that will be adjusted to circumstances that pertain at the time; we have to wait and see."

Last week the DH revealed that local PCTs would decide if pharmacists and their staff should receive the swine flu inoculation as a priority group. **CC**

Flu vaccine petition

Pharmacists have launched an online petition demanding the sector's inclusion in DH flu vaccine schemes. The petition, which calls for pharmacists and staff to receive both the swine flu vaccine and seasonal influenza jab, is at **http://tinyurl.com/kp43mh**

Carbamazepine storage

Tegretol liquid 100mg/5ml now has a shelf life of three years, manufacturer Novartis has said. The liquid should be stored below 30°C and kept in the outer carton to prevent light damage.

Diloxanide supply woes

Diloxanide tablets will be temporarily unavailable from September 1, manufacturer Amdipharm has said. The shortage is because the active ingredient is no longer being manufactured. This may lead to the product being discontinued, Amdipharm said.

Leo Pharma supply deal

Leo Pharma products will be exclusively distributed by AAH, Alliance Healthcare and Phoenix from October 1. Leo Pharma is the 16th manufacturer to enter into a supply deal. See our guide at **www.chemistanddruggist.co.uk**

Scottish payment updates

Some products are being rejected for reimbursement under Scotland's minor ailments scheme due to "issues" with the paymaster's database, the government has confirmed. The announcement came as part of a series of circulars about community pharmacy payments issued by the Scottish Government last week. Full details are at **www.chemistanddruggist.co.uk**

Hayfever P to GSL

The MHRA has launched a consultation on reclassifying a pack size of 14, 10mg loratadine tablets (Galpharm Non-Drowsy Hayfever and Allergy Relief Tablets) from P to GSL.
www.mhra.go.uk

Something about Mary

Producers of BBC2 television hit show Mary Queen of Shops have renewed calls for an independent pharmacy to volunteer for the programme. The show had already received 40 enquiries from pharmacists, but the door was still open to contractors wanting to star in the show, the producers have said. Email:
mgosney@cmpmedica.com

Boots and Lloyds back NPA after Co-op quits

Multiples retain membership and pledge support for association

Zoe Smeaton
zsmeaton@cmpmedica.com

The UK's two biggest multiples have backed the National Pharmacy Association, following The Co-operative Pharmacy's decision to quit the trade body.

Boots has signed up to the NPA until 2011, and Lloydspharmacy said it had renewed its membership for 2009. Next year's membership will be decided by a normal annual review process, a spokesperson for Lloydspharmacy said.

Boots healthcare public affairs director Tricia Kennerley said working together as an industry through the NPA could help develop the future of pharmacy.

The backing follows confirmation from the Co-op of its decision to leave the NPA. The multiple said it did not require the association's insurance services.

John Nuttall, managing director of The Co-operative Pharmacy, said: "We are in the fortunate position of being able to self-insure and as a result, The Co-operative Pharmacy does not require this core NPA function."

The NPA said it was in discussions with the Co-op about tailoring its offering to the needs of the pharmacy business.

Following The Co-operative Pharmacy's exit, the NPA received support from multiples Asda and Day Lewis.

Kirit Patel, chief executive of Day Lewis, told C+D he would be renewing the multiple group's membership and added that, in these challenging times, the NPA was giving support and training, and he felt the association was going in the right direction.

The Co-operative Pharmacy is the UK's third largest pharmacy chain after Boots and Lloydspharmacy.

A Boots store in Cleethorpes had to be temporarily closed after a 12ft sign blew down on to the pavement. No one was injured but one woman had to be comforted by shop staff. Police cordoned off the front of the store while debris, including cans and bottles that had collected behind the sign, were cleared away. A Boots spokesperson said they were conducting a full investigation into the incident. "The health and safety of our customers and staff is extremely important to us," he said.

Police appeal after Boots raid

Thieves have raided a Boots store in Berwick making off with perfumes worth £650.

The goods, which included aftershaves, eau de toilettes and deodorants, were snatched from an unsecured glass cabinet.

The incident follows a shoplifting spree earlier in the summer (C+D, August 29, p10), in which cosmetics and toiletries worth £3,700 were stolen from Boots and Lloydspharmacy stores in Surrey.

Police said the crimes were not connected.

Police have released CCTV pictures of two men and a woman who were seen in the Berwick area.

A police spokesman said the incident had been given extensive publicity. "This is a rural community and this sort of thing doesn't happen very often in this area."

A Boots spokesperson said the firm had invested in crime prevention in the store and had put in place a number of security measures. **FR**

GSK: Alli safe despite FDA fears

Pharmacists have been urged to go on selling Alli as usual following reports about potentially harmful side effects.

GlaxoSmithKline (GSK) defended the safety of the drug after reports linked orlistat – the active ingredient in Alli – to serious liver injury (C+D, August 29, p7).

The links are currently being investigated by The US Food and Drug Administration (FDA).

But GSK says the FDA's analysis of the data is ongoing and no definite association between liver injury and orlistat has been established.

A GSK spokesman said: "We are keen that pharmacists are fully informed to ensure consumers are not unnecessarily concerned." **FR**
www.chemistanddruggist.co.uk

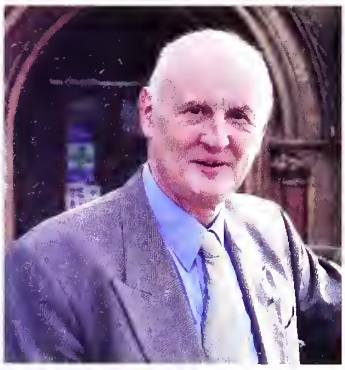
Richard Smith: Lloydspharmacy – transforming into a healthy living centre


Reap the skincare benefits of Aveeno®
Aveeno®
THE EMOLLIENT RANGE WITH COLLOIDAL OATMEAL

Dispensary talk

Should parallel trade be banned to safeguard UK stocks?

"At the moment it seems like a good idea. Ask me in six months, when the pound has gone up, and I might change my mind."
John Throup, Burrows & Close Pharmacy, Calverton



"If you're talking about manufacturers using that as an excuse to come out of normal supply, I'd say no. At the moment it's a farce."
David Badham, Stewart Pharmacy, Evesham

Web verdict

Yes 64%

No 36%

Armchair view: Pharmacists think parallel trade is part of the stock shortage problem, with two out of three respondents supporting a ban on drug exports.

Next week's question:
How often do you take a rest break during the day?
Vote at
www.chemistanddruggist.co.uk

AAH chief: clear stance needed on parallel trade

Wholesaler speaks out on pharmacists exporting medicines

Zoe Smeaton
zsmeaton@cmpmedica.com

Pharmacy needs to take a clear stance on whether exporting medicines is justifiable or not, an industry leader has said.

Simply saying it was legal and profitable might not be convincing if faced with criticism, warned Mark James, group managing director at AAH.

C+D has reported on pharmacists exporting medicines, which can be profitable given the low value of the pound, as a means to survive the financial pressures facing their businesses.

And comments posted on C+D's website have supported the practice, saying no disdain had been shown when pharmacists had chosen to import medicines previously.

Mr James said all it took was for a handful of pharmacists to raid wholesalers at the start of each month for other contractors to be affected by supply problems.

He said: "What is the balance between the rights of the few and those of the many? Wholesalers cannot and should not be the ones to make that decision: that must be down to the profession."

Mark James warned of reaction from the public and politicians

Mr James also warned of a possible reaction from members of the public and politicians if supply shortages were shown to be leading to patient harm.

"Simply saying [exporting] is legal and profitable will not make a convincing sound bite on the 9 o'clock news," he cautioned.

Where the industry stands

NPA: The NPA said it had a clear view on exporting and had reminded pharmacists of their obligations to operate within "the relevant legal and ethical frameworks, including the most recent RPSGB bulletins".

RPSGB: The Society has warned that exporting may not be ethical if it is contributing to supply problems. A law and ethics bulletin last month warned pharmacists to consider the impact of exporting.

PSNC: The organisation warned contractors that the practice could sully the reputation of pharmacy at its LPC conference in March.

Sector facing child protection regulation

Pharmacists face being regulated under a new scheme to protect children and vulnerable adults, the government has confirmed.

Pharmacists are likely to have to register with a safety watchdog under the Vetting and Barring scheme, which begins in October and will apply to "those providing frequent or intensive advice, guidance or treatment to a child or vulnerable adult".

The Home Office refused to rule out some pharmacy staff also having to register if considered to be in a position of trust with such customers. The news came after Asda Pharmacy voiced concerns about the cost to a pharmacy of registering all staff as well as pharmacists (C+D, August 22, p12).

Regulation could not be assigned to job titles, a Home Office spokesperson told C+D, but would be considered on a case by case basis. She said: "It will not apply to anyone who is simply engaged in retail and, unlike a qualified pharmacist, isn't carrying out a more specialist role.

"We believe this is a common sense approach."

The major pharmacy bodies were still "seeking clarity" on the scheme's application to pharmacists and pharmacy staff, said NPA NHS liaison manager Gareth Jones.

"Obviously we don't want any unnecessary administrative burden placed on pharmacies," he added. **JR**

Information script trial disappointing

Pharmacists have been surprised and disappointed by a "lack of interest" from customers over information prescriptions, research has found.

Pharmacists involved in a pilot scheme, who gave tailored written information to parents of children with conditions including epilepsy and asthma, found it "satisfying and straightforward" to deliver.

But recruitment of parents to the service was below expectations, found the research, published online by the journal Primary Health Care Research and Development.

Researchers recognised, however, that user opinion would be the "ultimate arbiter of its success". Wider evaluation of the pilot would be published later, researcher Stephen Tomlin told C+D. **JR**

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How to buy generics
www.actavisacademy.co.uk

Dead Sea cleanser has triple action

Ahava UK has extended its Source Dead Sea mineral skincare range with a new three-in-one facial product for tackling three skincare challenges.

Source 3-in-1 Mineral Toning Cleanser is suitable for all skin types and is designed to calm, clarify and tone the complexion.

It is a light water-based cleansing milk formulated to remove make-up, dirt and deep-seated skin impurities without irritating the delicate area around the eyes. In addition, it is formulated to tighten the pores and rebalance the skin's pH.

The product includes Ahava's Dead Sea mineral complex, Mineral Skin Osmoter, to help the skin to retain a balanced moisture level. It also contains Dunaliella algae (seaweed from the Dead Sea region, which is rich in beta-carotene); witch hazel for its astringent properties; and date plant extract, which has natural anti-inflammatory properties and is rich in vitamin E.

Ahava says the product's triple-action formula helps maintain soft and supple skin and acts as a base for the application of further face care products.

Price: £18.50/250ml
Ahava UK; tel: 01452 864574

Owen Mumford seals insulin pen supply deal

British medical device manufacturer Owen Mumford has signed a new three-year agreement with Sanofi-Aventis to supply the Autopen 24 reusable insulin pen for use with the drug manufacturer's insulin cartridges.

Autopen 24 is designed to be a comfortable, easy-to-use device for providing stable automatic insulin delivery. It features a side release button that is gently pressed and held to deliver the insulin dose.

Adam Mumford, sales & marketing director at Owen Mumford, said: "This new agreement with Sanofi-Aventis is a strong endorsement of the ease of use and effectiveness of Autopen 24 in assisting patients in the management of their diabetes.

"Sanofi-Aventis wants to provide maximum patient choice in the selection of the most appropriate insulin pen to suit individual needs and our partnership helps them achieve this goal."

Owen Mumford
Tel: 01993 812021

Bach flower kit aims to help emotional eaters

Nelsons is introducing a natural flower essences kit designed to help curb comfort eating.

Bach Emotional Eating Kit is a set of three flower essences that can be tailored to individual combinations and adapted to suit changing moods.

The kit includes the essences of crab apple, cherry plum and chestnut bud.

"Research shows that nearly half of all adults in the UK eat to change their negative moods and emotions," said Helen Bosley, brand manager at Bach Original Flower Essences.

The essences are produced according to Dr Bach's traditional methods, which date back 75 years, and contain no alcohol, artificial additives or colourings.

Price: £9.95
Nelsons; tel: 020 8780 4239

Single pack for Deep Freeze

Mentholatum's Deep Freeze Cold Patches are now available in single foil packs as well as in the original packs of four.

The flexible, adhesive cloth patch sticks to the skin at the site of pain to provide soothing relief for muscle and joint injuries. It is designed to work in a similar way to the effects of ice, helping to numb pain, stabilise the injury and promote healing.

The patch features a HydroGel layer containing water, menthol and aloe vera. The cooling action occurs through the evaporation of water from the HydroGel coating. Mentholatum says the cooling effect can last for up to three hours.

Lynn McGinness, senior brand manager, said: "Single patches are very convenient for people who want to keep one in their sports bag, one at work and perhaps one in the car so they can cool down sprains, strains and knocks whenever and wherever they occur without the mess and fuss of conventional ice packs or packs of frozen vegetables."

Price and Pip code: £1.49, 345-8411
Laser Healthcare
Tel: 01202 780558
www.mentholatum.co.uk

Migraine training on the web

GSK's Imigran Recovery is supporting a new series of audio podcasts designed to help pharmacy assistants deal with customers suffering from migraine.

Pharmacy assistants can listen to four podcasts at www.mypharmassist.co.uk or download them onto an MP3 player for their own convenience.

Topics include how to recognise a migraine, identifying triggers and treating migraine. The podcasts feature practical role play to help assistants when advising customers.

To coincide with Migraine Awareness Week (September 6-12), GSK is also introducing a new range of point of sale material designed to raise the profile of migraine and direct customers to their pharmacist for help, advice and, where appropriate, treatments.

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Retail talk

Did you notice a late flurry of holiday health sales as Brits booked a last-minute holiday abroad?

Yes 0%

No 100%

Off the shelf view:
A completely unanimous verdict this week, with no late peak in holiday health sales despite press reports that many Brits booked last-minute holidays abroad when our summer failed to live up to the weather forecasters' BBQ predictions. Perhaps they already had a stockpile of travellers' needs?

This week's question:
Are you selling more children's nutritional supplements as the new school year gets underway? Vote at **www.chemistanddruggist.co.uk/prodnews**

New name for Nestlé supplements

Nestlé Healthcare Nutrition has renamed three of its nutritional supplements that are available on FP10 and prescribed for patients with high risk of malnutrition.

Clinutren 1.5 is now called Resource Energy, Clinutren Fruit is now Resource Fruit; and Resource Benefiber is now Resource OptiFibre. The nutritional content of these products remains the same.

The Resource range provides specially designed sip feeds and desserts that are clinically proven to improve dietary intake, body weight and nutritional status in many clinical settings, says Nestlé.

Resource Energy is available in apricot, banana, coffee, chocolate, strawberry & raspberry and vanilla flavours. Resource Fruit comes in pear cherry, orange, raspberry & blackcurrant and apple flavours. All these products are packed in 4 x 200ml bottles.

Resource OptiFibre is available in 16 x 10g sachets and a 250g tin.

The name changes came into effect on September 1.

Nestlé Healthcare Nutrition
Tel: 020 8667 5130

Haliborange adds strawberry shapes for kids

Seven Seas Healthcare has launched a strawberry-shaped chewable multivitamin for children into its Haliborange range.

Haliborange Kids Multivitamin Fruit Softies have a strawberry fruit flavour and contain eight nutrients that may help promote healthy growth and development.

Suitable for children aged three to 12-years-old, the one-a-day multivitamins contain vitamins A, B, C, D and E.

Seven Seas will soon be releasing the next set of Shiny School master classes on the Haliborange website as part of a campaign launched earlier this year to help parents 'let their kids shine'. The new classes will focus on children's nutrition over the busy back to school period.

Price and Pip code: £3.99/30, 346-4229
Seven Seas Health Care
Tel: 01482 375234
www.haliborange.com

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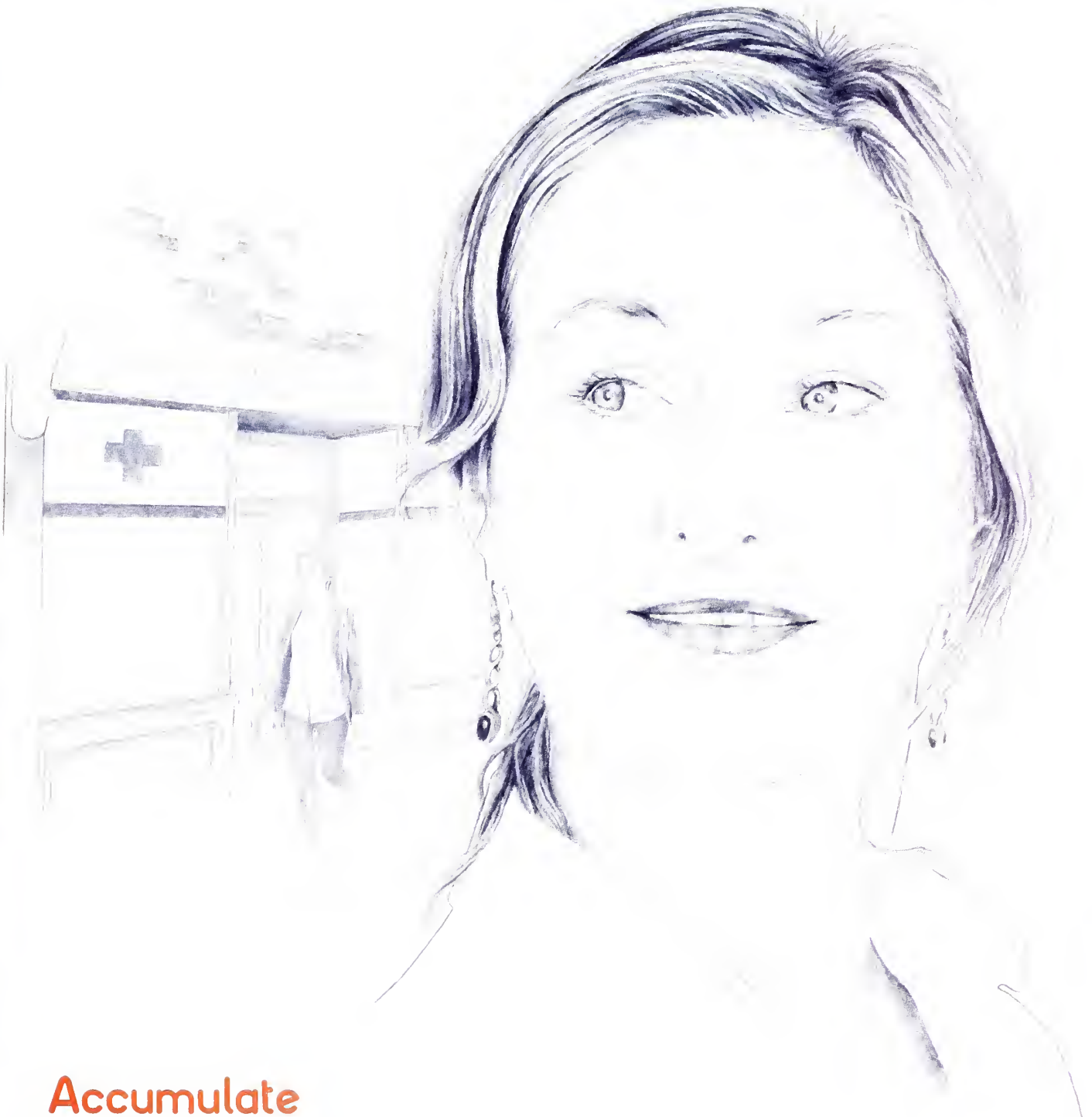

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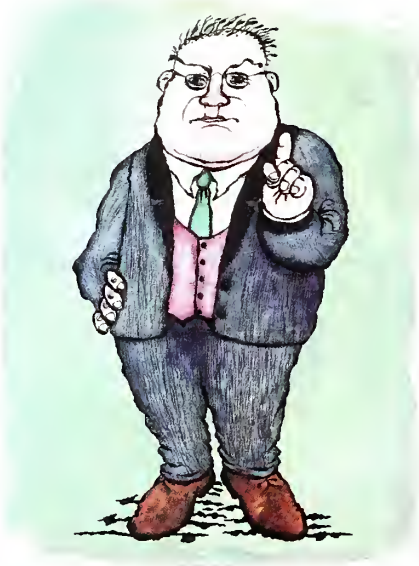
Give me some respect, not a vaccination



> PHARMACISTS SEEM TO LIVE IN A STATE OF PERPETUAL OUTRAGE AT HOW LITTLE RESPECT WE ARE SHOWN

Hands up, who thinks that pharmacists should be on the list of healthcare workers eligible for swine flu vaccination? Mmm, most of you. Now, hands up, who would actually get vaccinated if given the chance? Interestingly, not quite so many...

We were all shocked to hear that the Department of Health does not consider pharmacists important enough for routine vaccination. Not even as important as occupational therapists or student dentists, for heaven's sake! Pharmacists seem to live in a state of perpetual outrage at how little respect we are shown and how badly we are treated. I don't know why it hasn't sunk in yet – pharmacists haven't been considered worthy of decent pay and conditions for many years. A better coping strategy would be to accept that we're bottom of the pile and concentrate on working our way up.

I would consider missing out on this vaccination a lucky escape. A recent survey published on the Healthcare Republic website revealed that up to 60 per cent of GPs could refuse the vaccination, largely because of safety fears. Nobody tells the doctors what to do and we should take note of their reaction. The danger is that if we protest too loudly over this issue simply to make a point, all that vaccine earmarked for doctors and nurses could be injected into our arms instead.

The truth is that we feel most of our fantastic work goes unrecognised and we get all worked up at any sign that we're being badly treated. One of these days, someone will take notice of this constant moaning and we'll end up with more vaccinations, enhanced services and improved status than we could possibly manage. I suspect that many of us would suddenly be yearning for our comfy old doormat status.

On similar themes of swine flu and lack of respect, I'm amazed that the DH thinks it's a good idea to stockpile essential medicines. I wonder which part of the supply chain it thinks is going to fail in the pandemic. I'm confident that it won't be pharmacy or wholesale. As for the manufacturers, – I think they're already letting everyone else down with their quota schemes.

It seems that the DH has learnt nothing from the lessons of history. Community pharmacists are a hugely resourceful and flexible bunch and nothing short of Armageddon will stop them supplying needy patients with essential medicines. And taking pharmacy services into central control is always a disaster, as evidenced by the oxygen fiasco. Botched attempts at taking just one medicine, Tamiflu, outside the normal supply chain have demonstrated the enormity of the task. Central stockpiling of medicines could limit supplies to pharmacy and endanger lives.

We don't really want to be vaccinated; it's trust and respect we want. So trust us to do what we do best – supply medicines safely and consistently.

Rights and wrongs of cross-border trade

Not since the end of hostilities in 1945 have stocks of branded medicines in Northern Ireland been at such low levels. Indeed, it will take the equivalent of the Berlin Airlift to return stock levels to normal which, let's face it, was never great anyway.

I have vented my anger at wholesalers and smug customer-care people at pharmaceutical companies who snigger when I suggest that my wholesaler is out of stock of their medicine. I get only complex explanations about quotas, IMS indicative data and pricing variations across the EU; sadly no stock. No one is saying it, but it appears that too much of Northern Ireland's branded pharmaceutical stock has gone south.

I should really say little on this matter given that my maternal grandfather made a fortune transferring goods across the Irish border, some might call it smuggling. Born in 1901 he had great difficulty with the concept of an international boundary when one was created outside his front door in 1923, but a boundary separating two national jurisdictions had particular commercial benefits and he took full advantage, slowed only in 1951 when he was heavily fined for smuggling linen to the south and selling it to the Catholic Church for altar cloths. Linen exporting at that time was illegal; perhaps still is.

Stock shortages serve as a nice example of the difference between ethics and laws. Ethics tell us what we should do; laws tell us what we should not do. There is no law to stop community pharmacists in the north supplying wholesalers in the Republic of Ireland with UK branded pharmaceuticals. Recent falls in the value of sterling mean a lay out of £10,000 can make £2,000; not bad for chasing a few bits of paper and ringing up Parcelforce.

Perhaps only a few pharmacists engage in parallel exporting, but it is having a negative impact on patient care and that must be of concern to us all. Community pharmacy will be the loser as pharmaceutical companies move more towards direct-to-pharmacy schemes with resultant loss of margins. DHSSPS has already made comment and these activities will not help with contract negotiations. The short-term gain to some will create long-term pain that will be shared by all.

This seems wrong, but I am old enough to know there is no such thing as right and wrong; there are only opinions. And, if you wonder why I haven't followed in my grandfather's footsteps, perhaps it's because my father worked most of his life with HM Customs and Excise and, anyway, it's not illegal, so where's the fun?

Terry Maguire is a community pharmacist in Northern Ireland

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Features

Swine flu jabs

How to ensure you are picked for inclusion in your PCT's swine flu vaccination plans

Update: Adverse drug reactions part 5

How to spot and manage ADRs that lead to respiratory or cardiac problems

Risk and responsibility

The PDA sets out its concerns over the Responsible Pharmacist regulations

150 years of drug development

As part of C+D's 150th birthday celebrations, Gavin Atkin reviews 15 decades of new drugs

Incontinence

Find out why pharmacy is a perfect place for incontinence product sales

Jobs

NHS 24 medicines advisor Lesley Clark talks about her career with the Scottish telephone service

Will you get picked for the swine flu vaccine?

With PCTs set to allocate the swine flu vaccine to healthcare professionals, **Chris Chapman** asks how pharmacists can make sure they are included in plans

Last week the Department of Health revealed that PCTs would decide which healthcare workers in their area will qualify for the swine flu vaccine.

This opens the door for pharmacists to get the jab. But how can pharmacists make sure they are included in plans? And what are the implications of the move for the sector?

Mike Holden, chief officer of Hampshire & Isle of Wight LPC, has already succeeded in persuading PCTs in his area that pharmacists need the jab as a priority.

He says the secret to his success was the "hard-earned relationships" the LPC had forged with local PCTs, and the approach the LPC adopted.

"I was very proactive," he says. "As soon as [the vaccine announcement] went out I went to the directors of public health."

Mr Holden approached his local directors of public health, clinical directors and the PCT flu leads directly. He highlighted the roles pharmacists are playing across the PCT, using phrases in government vaccine guide the Green Book to show how the profession fit the criteria.

"The Green Book has specific language... one or two [health chiefs] gave me a little pushback, but we had a discussion and they totally agree [pharmacists should get the vaccine]."

Mr Holden's letter emphasised that pharmacists are "key frontline healthcare workers" who are "involved in direct patient care". The tactic paid off.

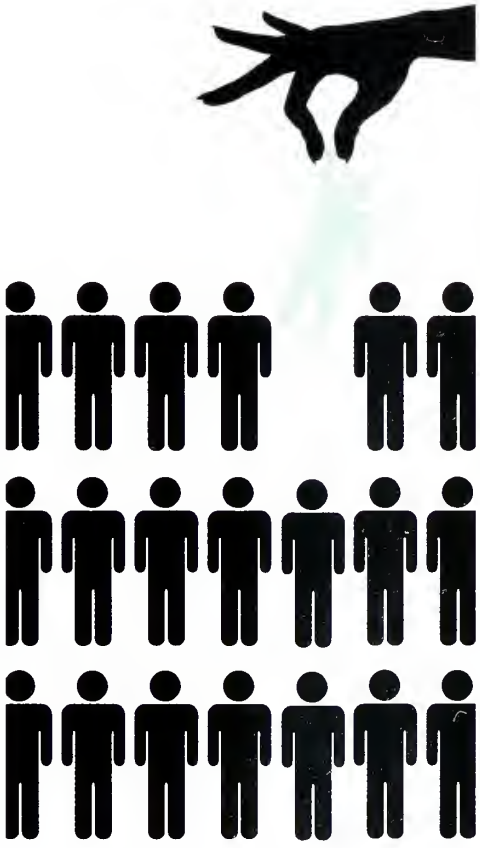
"The PCT has sent a letter to pharmacies asking for people who would qualify, and who their GP is, as that's the likely route it will be offered," Mr Holden says.

Mr Holden's success demonstrates that pharmacists can ensure their voices are heard at PCT level. And many PCTs are already aware of the role pharmacists are playing in the current crisis.

Medway PCT head of medicines management Hasseena Winter praises the "tremendous contribution" that community pharmacists have made. "At short notice, and with a very limited time scale, over half the pharmacy contractors in Medway PCT committed to offering an enhanced service for the distribution of antivirals," Ms Winter says.

Such praise would suggest PCTs understand the vital importance of the sector obtaining the jab, easing initial fears pharmacists would be left out of the scheme.

Yet while local arrangements seem the clearest option for the DH, they could create a headache for many of the sector's employers.



> THE PLAN FOR THE FIRST WAVE OF INOCULATIONS AIMS TO COVER AROUND TWO MILLION HEALTHCARE WORKERS

Lloydspharmacy pharmacy relations and governance director Andy Murdock believes there has to be a national framework for vaccination. His concern is that local decisions will create local variations.

According to Mr Murdock, around 20 per cent of Lloydspharmacy stores are involved in antiviral distribution. Lloydspharmacy employs more than 16,000 staff: if only 20 per cent were given the vaccine, how do you explain the situation to the remaining 12,800 employees? The PCT-based approach could make for some awkward conversations.

Other multiples, including Boots, are also trying to ensure the vaccine for their staff. Alliance Boots healthcare public affairs director Tricia Kennerley says the multiple is working on how they can support the DH plans.

"Once the DH has finalised its implementation plans we will be able to confirm further details with our people," she says.

But the idea of making decisions on vaccine distribution nationally is countered by Professor David Salisbury, the DH director of immunisation. He says that it's not feasible for blanket guidance on who should get the vaccine.

"We can give examples," Professor Salisbury says, "what we can't do is give absolutely strict definitions of every circumstance that needs to be considered... it's a matter for local discretion where people know who's at risk, and who isn't."

The NHS employed 701,324 professional clinical staff last year. Any central list would always cause some health professionals to fall through the cracks: with such a range of different jobs it is nearly impossible to know which workers have patient-facing roles.

That said, the DH plan for the first wave of inoculations aims to cover around two million healthcare workers – enough in theory to include all clinical workers, including pharmacists, almost three times over. This suggests pharmacists and staff will not be overlooked.

But ultimately there are too many unknown variables to be sure who will be vaccinated in time. The swine flu vaccine is expected to be licensed in late September at the earliest. Experts have predicted a second wave of the pandemic in the autumn.

As Professor Salisbury highlights, plans are only a work in progress until manufacturers give details of what will be supplied.

"Until we know exactly how much vaccine will come, per week, and how that will be adjusted to the circumstances that pertain at that time, we will have to wait and see."

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Update

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Module 1493

ADRs affecting heart and lungs

What to look out for and how to manage possible side effects

Professor Janet Krska

CASE STUDY

Mr PR, aged 53, has had angina for several years and was diagnosed as hypertensive six months ago, which has proved difficult to control. He was told at that time that he was obese (BMI 31kg/m^2), so should lose weight and should stop smoking. His current drug therapy is bendrofluazide, enalapril, atenolol and GTN spray.

You have provided him with NRT and support to stop smoking and he has gone for two months without a cigarette. However, when you next see him he complains he still feels breathless and his long-standing cough is becoming more irritating, although it is less chesty and productive. He has used his favourite Do-Do tablets with no effect and tried a cough mixture recommended by a friend that didn't help.

What questions should you ask and what advice can you give? See the SCOOTA (symptoms/severity, causative drug, other causes, outcomes, timing and actions) box at the end of this article.

Respiratory ADRs

Although most respiratory conditions presenting in community pharmacy are likely to be infectious, some may be due to drug therapy. The most common are breathlessness, cough and nasal congestion.

Breathlessness

Breathlessness can be caused by a variety of drugs, some of which are used to treat respiratory conditions. Inhaled beta agonists, including long-acting beta agonists, steroids, ipratropium and cromoglicate, can all cause paradoxical bronchospasm, probably by simple irritation of the bronchial mucosa. The patient may experience an immediate increase in wheezing after inhaling the product and peak flow is reduced.

In the case of long-acting beta agonists, it has been suggested that bronchoconstriction is due to the slow onset of action. As well as affecting breathing, long-acting beta agonists and cromoglicate can irritate the throat, while tiotropium can lead to irritation of the upper airways, including pharyngitis and possibly sinusitis.

Patients with a history of asthma or COPD can experience severe breathlessness from a single dose of a beta-blocker, resulting from contraction of the smooth muscle and/or antagonism of the effect of beta-agonists. However the careful use of cardio-selective beta-blockers is possible if required in some patients with COPD.

Aspirin and NSAIDs are traditionally associated with bronchoconstriction due to hypersensitivity reactions, particularly in asthmatic patients. Some 21 per cent of asthma sufferers have aspirin sensitivity. Women and patients with a history of sinusitis, allergic rhinitis or chronic urticaria seem to be at greater risk of NSAID hypersensitivity. Symptoms can be severe and may be accompanied by rhinorrhoea, urticaria or other typical allergic symptoms. Patients with a history of these symptoms need to avoid aspirin and other NSAIDs, particularly non-Cox-selective drugs, because there is a high incidence of cross-reactivity. Some aspirin-sensitive patients can also experience symptoms with paracetamol.

Breathlessness can arise as a result of reduced cardiac output leading to congestive heart failure. Drugs with a negative inotropic effect can precipitate or worsen pre-existing heart failure. Beta-blockers and the calcium channel blockers diltiazem and verapamil are most associated with breathlessness or worsening of mild heart failure, although beta-blockers are useful in managing severe heart failure. Increased fluid retention also leads to breathlessness through reduced cardiac performance. NSAIDS, corticosteroids and high salt intake associated with some antacids can all cause this problem, especially in patients with pre-existing mild to moderate heart failure.

Nebulised ipratropium should be initiated under medical supervision in case paradoxical bronchospasm occurs. Bronchospasm related to long-acting beta agonists or cromoglicate usually requires cessation of therapy, but the immediate breathlessness can be treated with a fast-acting bronchodilator. Breathlessness due to cardiac failure requires drug discontinuation and selection of an alternative treatment, when this is possible. Acute bronchospasm from aspirin or NSAIDs occurring shortly after ingestion can be life-threatening and is a medical emergency.

Cough

ACE inhibitors are a well-known cause of cough. The reported incidence varies, but may be as high as 20 per cent. Diagnosis is made more difficult because the interval between initiation of the

60-second summary

What ADRs could lead to respiratory symptoms?

Breathlessness can result from drugs used in respiratory conditions such as inhaled beta-agonists and steroids. Asthmatics can suffer bronchoconstriction with beta-blockers, aspirin and NSAIDs; drugs reducing cardiac output can cause heart failure and ACE inhibitors may cause cough.

What about cardiovascular ADRs?

Antihypertensives can both increase and decrease heart rate. Tachycardia can be a side effect of sympathomimetics, antimuscarinics and nitrates, while tricyclic antidepressants can cause abnormal cardiac rhythms. Drugs increasing sodium and water retention can raise blood pressure, whereas others may cause postural hypotension.

This article (Module 1493) can help make following CPD competences: C1a, C1e, C1e, C1e, C1e, C1b, C2a, C3j.
See http://tinyurl.com/68ex7b

drug and the symptom can vary from a few days to over a year. The cough is typically dry, non-productive and irritating. It persists despite cough suppressants and can lead to sleep disturbance and sore throat. Stopping the ACE inhibitor may relieve the symptoms within a few days but in some patients it can persist for as long as six months, thus further adding to the difficulty in diagnosis. The cause is that bradykinin accumulates because its breakdown is inhibited by ACE inhibitors. Angiotensin-2 receptor blockers can be used instead, however, as they do not affect bradykinin.

Amiodarone can cause cough in up to 10 per cent of patients taking it, as part of pulmonary toxicity. Cough may be accompanied by breathlessness and chest pain and can progress to serious, life-threatening conditions. Methotrexate and gold can cause cough as part of pulmonary hypersensitivity reactions, which may also be accompanied by breathlessness and possibly fever.

Management of all pulmonary toxicity requires expert medical advice.

Nasal congestion/irritation

The most frequent cause is overuse of topical nasal decongestants arising from tolerance to the vasoconstrictors. It develops after a few weeks of continuous use, leading patients to increase the frequency of dosing. Patients should be advised to stop using the product and symptoms should subside within a few days.

Local irritation can also occur with nasally administered formulations, including decongestants, steroids and sumatriptan. With nasal steroids this can lead to bleeding.

Nasal congestion is a common side effect of phosphodiesterase inhibitors, affecting around 10 per cent of patients, because of increased blood flow in the nasal mucosa. Vardenafil has also been associated with nasal bleeding and breathlessness. Given the use of these in erectile dysfunction, patients may be willing to tolerate this problem.

Cardiovascular ADRs

Probably the most likely drug-related problems to present to pharmacists are changes in heart rate and blood pressure.

Changes in heart rate

Tachycardia may be caused by products obtained without prescription, including sympathomimetics such as pseudoephedrine, theophylline, caffeine and nicotine. Nicotine causes tachycardia through release of noradrenaline. When trying to stop smoking, reduced nicotine levels can lead to bradycardia, which is countered by nicotine replacement therapy. Tachycardia as a side effect of NRT is therefore uncommon.

Tolerance develops rapidly to the effects of caffeine, but palpitations can be a sign of overuse. Many patients are unaware that some analgesics contain caffeine, so it is possible to increase daily intake considerably when taking these for minor ailments at the same time as caffeine-containing drinks.

Beta agonists, drugs used in managing ADHD and sibutramine cause tachycardia due to their sympathomimetic effect. Antimuscarinics, mainly those used in parkinsonism, as well as older antidepressants and antipsychotics also increase heart rate. Tachycardia is most likely to occur with high doses of inhaled beta agonists and antimuscarinics, especially nebulised solutions.

Increased heart rate is a physiological response to reduced blood pressure so many antihypertensives cause tachycardia, including calcium channel blockers and diuretics. Nitrates result in tachycardia due to vasodilation, as do phosphodiesterase inhibitors. One of the physiological effects of thyroxine is increased heart rate, but it should not normally occur with replacement therapy. If it does, this indicates overdose that, if left unresolved, can lead to atrial fibrillation. Fibrillation can also be precipitated by digoxin, corticosteroids and some antidepressants. Tricyclic antidepressants are associated with abnormal cardiac rhythms, especially amitriptyline. Galantamine can cause tachycardia and arrhythmias.

Bradycardia is a pharmacological consequence of many drugs used to manage arrhythmias and hypertension and using them in combination increases this risk. Patients may present with fatigue, light-headedness, fainting or falls. In this situation, careful questioning may help to clarify the association with any newly-prescribed medicines but, since management will involve balancing the risks of bradycardia against the benefits of treating cardiovascular problems, referral is usually required.

Changes in blood pressure

Raised blood pressure may be picked up during cardiovascular or other screening in the pharmacy. Drugs that increase sodium and water retention, including NSAIDs, corticosteroids and high salt intake in diet or in antacids can increase blood pressure. Sympathomimetics increase blood pressure along with heart rate (see above). Buproprion has been reported to cause hypertension, both alone and in combination with NRT. In some cases this can be severe, requiring acute treatment. Pre-existing hypertension increases the risk of this problem. Similar problems can occur with venlafaxine, and oestrogen-containing oral contraceptives are associated with increased incidence of hypertension.

With all these drugs, blood pressure should be measured before they are started and regularly throughout treatment. Triptans can either increase or decrease both blood pressure and heart rate, but generally increased blood pressure and tachycardia are most likely.

Reduced blood pressure is most often detected as postural hypotension, occurring as dizziness and fainting on rising from a sitting or lying position. Pharmacists will no doubt be aware of this problem in relation to falls assessment. Postural hypotension is common with many antihypertensives, especially alpha blockers, ACE inhibitors and angiotensin-2 receptor blockers, but also occurs with diuretics, centrally-acting antihypertensives and nitrates. Other drugs causing postural hypotension include older antipsychotics, tricyclic antidepressants, SSRIs, levodopa and other dopaminergics, antihistamines and opioids. The combination of several drugs causing postural hypotension, while common, increases its likelihood, as does increasing age.

Management

Gradual dose titration can prevent problems with hypotension and bradycardia, while generally keeping the dose of all drugs as low as possible and reducing dosages are the main strategies employed to minimise all these problems. The role of the pharmacist is therefore important when new therapies are initiated, when conducting MURs or falls assessments, and when patients present with symptoms.

Janet Krska is professor of pharmacy practice, Liverpool John Moores University.

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online.

CASE STUDY ACTION POINTS

COOTA can help you to identify key questions and actions

Symptoms/severity: Find out about changes in Mr PR's breathlessness and its severity.

Causative drug: Breathlessness could be caused by atenolol, though not enalapril. Ask about compliance and dose changes.

Other causes: Excess weight can contribute to breathlessness and obviously both this and the cough were caused by smoking but it would be expected that if Mr PR has not smoked for two months these symptoms should have improved considerably by now. So ask about weight changes and check on current smoking. Does he have any history of asthma that could be worsened by atenolol?

Outcomes: Symptoms not relieved by theophylline or cough mixture. What did he use?

Timing: Check in Mr PR for the dates he started therapy with both atenolol and enalapril. But also find out when the cough changed and the breathlessness started.

Actions: He has tried OTC remedies, but has he considered that POM drugs may be implicated, and may have seen his GP about the symptoms?

Depending on what he says, it is probable that Mr PR will need to see his GP, as his drug therapy may be implicated and need changing. As his blood pressure has been difficult to control he should be regularly monitored.

NEXT WEEK'S UPDATE
A series of Update articles on drug misuse starts with what constitutes addiction.

ADRs affecting respiratory and cardiovascular systems

Reflect

Which patients are most likely to suffer from NSAID hypersensitivity? Why do ACE inhibitor drugs produce a dry cough side effect? Which drugs may cause unwanted changes in heart rate?

Plan

This article discusses the drugs that may produce respiratory and cardiovascular side effects. It includes the side effects of breathlessness, cough, nasal irritation, and changes in heart rate and blood pressure.

Act

If you have not already done so, read the author's previous articles on adverse drug reactions, which can be found on the C+D website at http://www.chemistanddruggist.co.uk/update.

Find out more about NSAIDs and asthma from a leaflet produced by the National Asthma Council of Australia at http://tinyurl.com/km6ckl.

Find out more about the ACE inhibitor cough from the International Society for the Study of Cough at http://tinyurl.com/nd7pcl.

Think how you can use the information in the article when counselling patients. Would it help when carrying out MURs or falls assessments for example?

Evaluate

Are you now more aware of the drugs that can cause respiratory and cardiovascular side effects? Could you spot a possible adverse drug reaction?

5 minute test

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Get a CPD log sheet for your portfolio when you successfully complete the 5 Minute Test online

Practical Approach

To exercise or not in arthritis?

Beverley Barber is a home carer who regularly collects prescriptions at the Update Pharmacy for elderly patients. The staff have come to know her well. One day, in the course of conversation with pharmacist David Spencer, she says: "David, you seem to be pretty knowledgeable about most things medical, I wonder whether you can give me some advice?"

To see the full archive of Practical Approach articles go to **www.chemistanddruggist.co.uk/practicalapproach**

"If I can," David replies. "What's it about?"

"Well, 25 years ago, when I was 30, both my legs were badly injured in a car accident. I had a steel rod put in my left femur and a full cast on my right leg, and I was in traction for two months. The doctors told me I would never walk again. As you can see, they were wrong but ever since I've had pain in my knees and hips.

"About 15 years ago I was told I had osteoarthritis as a result of the injuries. Luckily, the pain isn't too bad and I can control it with paracetamol. The doctors told me I should never do any impact exercise, although aquaerobics would be OK. I've been going to a class for years, but it doesn't really make me feel fit and I'm putting on weight.

"I've not got much confidence in the medical advice I've been getting and I wonder whether I could do some more strenuous exercise without aggravating the arthritis?"

Questions

1. What is the current view of exercise for osteoarthritis sufferers?
2. What would be the specific benefits for Beverley?
3. What exercise could she do to improve her general health and mobility?
4. What precautions should she take?

Answers

1) Physically active people, including those with arthritis, are healthier and live longer than those who are not. Inactivity exacerbates the consequences of arthritis, including muscle weakness and atrophy, decreased flexibility and cardiovascular fitness, osteoporosis, depression and lowered pain threshold. In the past it was believed that rest would benefit inflamed joints and promote healing. However, recent studies have shown that people with osteoarthritis can tolerate and, indeed, benefit greatly from, weight-bearing exercise such as walking.

2) Regular motion and weight-bearing exercise: nourishes cartilage and bone and strengthens joints; decreases feelings of depression and improves sleep and mood; promotes general health; strengthens muscles around joints to protect them and absorb shock, decreases pain and stiffness; strengthens bones and reduces the risk of osteoporosis and injury; decreases the risk of heart disease; improves energy levels.

3) Up to 30 minutes of moderate aerobic activity on most days of the week, plus daily gentle stretching exercises, encompassing the whole body.

4) Take care not to overstretch lax joints. If joint pain and swelling follow activity, treat as an 'overuse' injury, with ice and rest. On days when the disease flares in joints, alternate activities so the exercise habit is maintained but the joints are protected.

This article is worth [illegible] CPD competencies **G1a, G1b, G1d, G1q, G2o, C1f, C2c.**
See http://tinyurl.com/68ox7b

Further reading

King, SB, Minor, MA. Osteoarthritis and exercise. Virtual Health Care Team. University of Missouri – Columbia, School of Health Professions. www.vhct.org/case2100/index.htm

Risk and responsibility

Still wondering whether the Responsible Pharmacist regulations are good or bad? The **Pharmacists' Defence Association** has been vocal on the issue and highlights its key concerns

Imagine this: as a pharmacist, you – and not your area manager or superintendent – get to decide what is a safe staffing level in your pharmacy. Imagine that you make the final call on what is an appropriate workload in terms of the services you provide from that pharmacy.

Sound appealing? The above scenario could be one of the tantalisingly attractive advantages of new regulations that were proposed to give pharmacists statutory authority over important operational matters within the pharmacy – the Responsible Pharmacist (RP) regulations.

The plan to replace some of the outdated provisions in existing legislation with updated regulations was in principle a very good one. Yet the Pharmacists' Defence Association (PDA), the pharmacists' union, last week met with the Department of Health (DH) to formally request a delay in the RP regulations due to come into effect next month – because it believes some of the requirements are unworkable.

Here the PDA outlines the requirements it believes may cause the most major problems, and how they could affect you.

A pharmacy may only operate if it has an RP signed on.

The problem:

Rest breaks. The regulations allow for the RP to be absent for up to two hours, but these are designed to cover situations where the RP is working away from the pharmacy, for example, visiting a local GP surgery or residential home. In these instances, the RP remains signed on and, as a result, the pharmacy is allowed to continue to operate a limited scope of activities.

The two-hour absence provision cannot be used to accommodate rest breaks, not because this is professionally prohibited but because it conflicts with the law on rest breaks. A rest break must be a full physical and mental break away from the workstation; a person cannot be expected to carry any responsibility for the workplace while they are on their statutory break. This means that the RP must 'sign off' if the full legal requirements of a rest break are to be observed.

What it could mean for you:

Either:

- another pharmacist must sign on to be an RP for the duration of the original RP's rest break, or
- the pharmacy must cease to operate while there is no RP signed on.

If it was the intention of the new regulations to update some of the provisions of the 1968 Medicines Act, such as the inability to sell GSL medicines while the pharmacist was at lunch, then it has failed to do so.

If employers attempt to persuade pharmacists they should remain signed on and use the two-hour absence for their rest break, pharmacists will not in fact be getting their lawful rest break; they will effectively be working through. Employers then risk legal consequences for breaches under employment legislation (which will apply to employed pharmacists) and health and safety legislation and professional breaches (which will apply to both employed and self-employed pharmacists).

If signed on, RPs will be held legally accountable if something goes wrong in the pharmacy whether they are present or not and irrespective of what they have agreed privately with their employer with respect of their break.

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actavis
creating value in pharmaceuticals

Pharmacy activities will be allowed to occur only if there is an RP signed on at the time that they are being undertaken.

Currently, many 'patient-facing' pharmacy activities occur outside of opening hours; for example, preparation of MDS packs for residential homes, and bulk stock preparations.

Either:

- the RP will need to start their work shift earlier or stay later than before so as to be physically present, or
- work patterns will need to be changed so that they are undertaken during normal working hours, or
- another RP will need to sign on for the unsociable extra hours, or
- an RP will need to physically sign on remotely before arriving at the pharmacy at the time these activities commence at the pharmacy (with a maximum of two hours elapsing before the pharmacist arrives at the pharmacy).

In the last option, an RP would be taking on the full statutory and professional responsibility while absent and without even having arrived at the pharmacy to assess whether all is as it should be. This solution would only be appropriate in certain situations, such as where an owner proprietor or regular manager is entirely familiar with the pharmacy procedures and is prepared to operate in this way.

Professional common sense dictates that before signing on remotely, the pharmacist would need to check that all of the expected conditions are indeed in place and that nothing detrimental had occurred overnight that could affect the safe and effective running of the pharmacy. The RP may be asked to sign on in this way by an employer – but the decision to do this is strictly for the RP to make and only then if the RP is satisfied that they can secure the safe and effective running of the pharmacy.

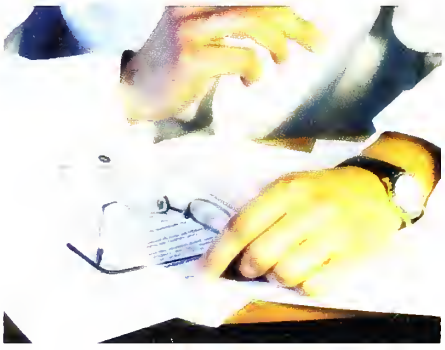
If the RP did feel comfortable with such a solution then they would need to consider an amended employment contract and remuneration arrangement. This solution would not be suitable for an emergency locum as it would be unreasonable to expect them to take on such statutory responsibility in absentia.

The Pharmacists' Defence Association: www.the-pda.org
Online petition to delay the RP regulations: www.gopetition.com/petitions/postpone-the-rp-regulations.html
Tools and advice to prepare for the RP regulations: www.responsiblepharmacist.com

The pharmacy procedures are to be governed by nine principles contained in the RP regulations and pharmacists must be satisfied that these can secure the safe and effective running of the pharmacy before they sign on as an RP.

It will be very difficult to read, digest and either accept or amend a pharmacy procedure having just arrived in a pharmacy that has queues of patients already waiting to be served, unless of course such a pharmacist is an owner or regular manager.

The PDA believes that one pragmatic solution to this problem is that a standard headline document, of no more than two pages, covering the nine points is agreed by the profession collectively as the broad template with which pharmacists can familiarise themselves.



This document could then be used by RPs when they take on the RP responsibility. Importantly, they would only sign on as RP if they could be satisfied that the pharmacy was able to operate to those described standards and that they could ensure the safe and effective running of the pharmacy. If they could not, then the pharmacists would have a choice to either:

- establish a new set of procedures – this might mean that the pharmacy operation would be reduced or otherwise amended in some way, or
- not sign on as an RP and then immediately escalate their concerns to the superintendent.

The problem with both of these solutions is that there are currently few professional and legal protections for pharmacists who may then be disadvantaged by employers.

New 600 ml pack sizes last longer

With eczema, it's important to recommend a daily routine of a bath emollient and cream.[1] To support your advice Oilatum® is now launching a range of 600 ml packs.

They're bigger, last longer and help improve customer convenience. Our new packs also provide good trade value for you:

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New 600 ml pack sizes

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Oilatum

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Oilatum Junior Emollient Bath Additive Essential Information
Active ingredients: light liquid paraffin 63.4% w/w. **Uses:** For the treatment of contact dermatitis, atopic dermatitis, ichthyosis and related dry skin conditions. Oilatum Junior Emollient Bath Additive is particularly suitable for infant bathing. **Dosage and administration:** Suitable for use in infants and children. Oilatum Junior Emollient Bath Additive should always be used with water, either added to the water or applied to wet skin, and may be used as frequently as necessary. Add 1-3 capfuls to an 8-inch bath of water, soak for 10-20 minutes, and pat dry. Infant bath: Add ½-2 capfuls to a basin of water, apply gently over entire body with a sponge, and pat dry. **Side effects, precautions and contraindications:** Take care to avoid slipping in the bath. If a rash or skin irritation occurs, stop using the product and consult with the doctor. Consult the SPC for further details. **Legal category:** GSL. **Package quantities & trade price:** 150ml £2.82, 250ml £3.25, 300ml £5.10, 500ml £5.75 and 600ml £5.89. **Product Licence number:** PL 0174/0182. **Marketing Authorisation Holder:** Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concorde Road, Maidenhead, SL6 4BY, UK. **Date of preparation:** August 2009.

Oilatum Plus Essential Information
Active ingredients: light liquid paraffin 52.5% w/w, benzalkonium chloride solution 6% w/w, triclosan 2% w/w. **Uses:** For the prophylactic treatment of eczemas at risk of infection. **Dosage and administration:** Oilatum Plus should always be diluted with water. Adults and children: Add 2 capfuls to an 8 inch bath or 1 capful to a 4 inch bath. Infants: Add 1ml to a basin of water and mix well. Do not use in babies younger than 6 months. **Side effects, precautions and contraindications:** Avoid contact of the undiluted product with the eyes. If the undiluted product comes into contact with the eye, reddening may occur. Eye irrigation should be performed for 15 minutes and then the eye examined under fluorescein stain. If there is persistent irritation or any uptake of fluorescein, the patient should be referred for ophthalmological opinion. The product should not be used with soap. Keep out of the sight and reach of children. Consult the SPC for further details. **Legal category:** GSL. **Package quantities & NHS price:** 500ml £6.98 and 600ml £8.05. **Product Licence number:** PL 0174/0070. **Marketing Authorisation Holder:** Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concorde Road, Maidenhead, SL6 4BY, UK. **Date of preparation:** August 2009.

Oilatum Emollient Essential Information
Active Ingredients: light liquid paraffin 63.4% w/w. **Uses:** For the treatment of contact dermatitis, atopic dermatitis, senile pruritus, ichthyosis and related dry skin conditions. **Dosage and administration:** Oilatum Emollient should always be used with water, either added to the water or applied to wet skin, and may be used as frequently as necessary. Adult bath: Add 1-3 capfuls to an 8-inch bath of water, soak for 10-20 minutes, and pat dry. Infant bath: Add ½-2 capfuls to a basin of water, apply gently over entire body with a sponge, and pat dry. Skin cleansing: Rub a small amount of oil onto wet skin, rinse and pat dry. **Side effects, precautions and contraindications:** Take care to avoid slipping in the bath. Keep out of the sight and reach of children. Consult the SPC for further details. **Legal category:** GSL. **Package quantities & NHS price:** 250ml £2.75, 500ml £4.57 and 600ml £4.68. **Product Licence number:** PL 0174/5010R. **Marketing Authorisation Holder:** Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concorde Road, Maidenhead, SL6 4BY, UK. **Date of preparation:** August 2009.

1 NICE Guidelines. Atopic eczema in children. December 2007 Available at http://www.nice.org.uk/guidance/inde.jsp?action=download&o=38559.

OL7179

15 decades of... new drugs

C+D 150

Drug development has changed UK life since C+D was born 150 years ago, says **Gavin Atkin**. He celebrates the cream of the crop

Reliable doses and reduced side effects have paved the way for modern pharmacy practice that would have been scarcely imaginable in the 19th century

Mankind has made huge progress in the past 150 years – but few things can have improved our lives more than pharmaceuticals.

Perhaps the most conspicuous change is that treatments developed and introduced during the lifetime of this magazine have revolutionised family life in the UK. Some 150 years ago, families and children expected to live in the midst of death, and adapted to life as part of a slowly unfolding tragedy punctuated by loved ones regularly passing away from mysterious diseases such as diphtheria, chicken pox, scarlet fever, rubella, cholera, dysentery, tuberculosis, syphilis, meningitis and post-partum infections.

The point is made by photos of Victorian living rooms, which were often small shrines stuffed with sad photos and mementoes commemorating those who had gone before. Today, however, the words 'life expectancy' have a positive gloss – particularly if we are reasonably healthy in our lifestyles, we expect to live for many years and to do so without too many disabilities or pain. And if we have chronic diseases, we expect their effects to be controlled by treatments that exist in most disease areas. More, those who can't afford to pay for drugs don't have to go without unless evidence that they're cost-effective is lacking, and we expect patients will receive similar treatments wherever they live.

So which of the great developments of the past century and a half have delivered the really big benefits? At the time C+D was first published in 1859, a wide range of treatments based on organic materials derived from plants was well established. Some, including opium and squill, could be traced back to the Roman philosopher and apothecary Galen, while others, such as digitalis, were much more recent. But big changes were coming.

Louis Pasteur and later Robert Koch were busy establishing the germ theory of disease, carbolic acid was being adopted by surgeons, and the concept of immunisation was taking hold in the next few years – in three short years between 1879 and 1882, Pasteur himself developed vaccines against cholera, anthrax and rabies.

Another key theme of the later 19th century was the development of techniques for isolating active ingredients from plants. Isolating active ingredients enabled those treating patients to dispense reliable doses and reduced side effects, and paved the way for something like modern pharmacy practice. More, it set the scene for pioneering pharmaceutical scientists to analyse existing treatments and create new ones.

Brought in to reduce the problems that seemed to be associated with urban living in the 19th century, it ensured new housing had running water and a drainage system, and had a huge impact on public health – bigger perhaps than any of the drug treatments of the period.

Cocaine comes into use as a local anaesthetic, after Sigmund Freud (right) suggested the possibility to surgical colleagues in Vienna. Surgeon friend Carl Koller conducted successful initial experiments using it in eye surgery. Later, alternatives such as procaine and lidocaine were adopted.

1912 Phenobarbital

The antiepileptic is introduced and becomes the preferred treatment. It replaces bromides, which have a variety of side effects including loss of appetite, nausea and sleepiness.

Louis Pasteur promotes the germ theory, and develops cholera, anthrax and rabies vaccines.

1899 Aspirin

Bayer launches acetylsalicylic acid under the trade name Aspirin in 1899. It was used as a combination treatment with heroin.

1909 Salvarsan

'Salvation through arsenic' was an early antimicrobial used in treating syphilis. It was a huge development at a time when as many as one in 10 had the disease, with all its dreadful consequences, including blindness.

Greater commitment both nationally and locally.

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September 7th is a very important day for your future professional body.

At the British Pharmaceutical Conference we will announce a list of commitments that underline how the PLB intends to become the body you've asked for.

A professional leadership body with a new structure that gives more accountability to the Boards in England, Scotland and Wales. A body that sets up Local Practice Forums, listens to its members and that puts your interests at the heart of everything it does.

Of course, fulfilling these commitments can't happen overnight – so we're asking for 100 days to show you we mean what we say.

You'll find the commitments in full from September 7th at **www.pharmacyplb.com**

COMMITMENT TO PHARMACY

wain, Chair,
English harmacy Board

novan, Chair,
harmacy Board

Sandra Melville, Chair,
Pharmacy Board

[illegible] working with the profession
to create [illegible] professional leadership
body for pharmacy

www.pharmacyplb.com

1922 Insulin

Working in Toronto, Frederick Banting and Charles Best (right) isolate insulin. Eli Lilly and others devote large-scale resources to produce enough of the drug to treat patients with diabetes. Banting and Best sell their interest in the product for $1 in order to make insulin available to the most patients as early as possible.

Mid 40s Penicillin

Although the antibacterial potential of compounds derived from the penicillium mould was identified in 1928 by vaccines expert Alexander Fleming, it wasn't until the 1940s that researchers found a way to produce penicillin in quantity. An early aim was to produce enough for the casualties expected during the D-Day landings in 1944.

1953 Chlorpromazine

Rhône-Poulenc licensed the revolutionary antipsychotic chlorpromazine to Smith, Kline & French (today's GlaxoSmithKline). Initially studied for its sedating effects, it was quickly found to improve patients' thinking and emotions.

1927 Thyroxine

Thyroxine is first synthesised by Charles Harington.

Mid 30s Sulfa drugs

Bayer launches the bacteriostatic drug sulphanilimide after trials showed it reduced mortality from puerperal fever. May & Baker later develops sulphapyridine.

1948 Corticosteroids

A cheap means of synthesising cortisone from soy beans is developed in the USA and tried in a series of rheumatoid arthritis patients, in whom the drug produces dramatic improvements.

Mid 50s Diphenhydramine

The first antihistamine, diphenhydramine, was launched by McNeil-PPC under the brand name Benadryl.

1966 Cimetidine

Work on antihistamines led to the development of cimetidine, which acts on histamine receptors in the stomach.

1961 The Pill

Conovid, the first contraceptive pill, was launched in the UK by Searle. It would be made available on prescription at a cost of 2 shillings.

Late 50s Chlordiazepoxide

The first benzodiazepine, it was supplied by Hoffman La Roche under the brand name Librium.

1956 Paracetamol

Paracetamol 500g launched in UK as a prescription treatment. It later became a popular OTC treatment under the trade name Panadol.

1968 Salbutamol

Developed by Allen & Hanbury, the short-acting adrenergic receptor agonist is launched for the treatment of asthma under the name Ventolin.

1964 Ibuprofen

Boots researchers working on carboxylic acids develop ibuprofen, which is launched as a prescription drug called Brufen.

Late 50s Imipramine

The first tricyclic antidepressant, imipramine was developed by Geigy – before this the only treatments available were psychotherapy and electroconvulsive therapy.

1956 Mitomycin

The success of penicillin prompted the identification of many more antibiotics, some of which were found to halt cancer cell division. Mitomycin was the first cytotoxic antibiotic treatment, and was used to treat stomach and breast cancer.

Mid 70s Lithium

Although first identified many years before, lithium finally comes into use in controlling symptoms in patients with bipolar disease.

1986 Zidovudine

Developed by Burroughs Wellcome & Co researchers, zidovudine inhibits the action of reverse transcriptase, which retroviruses such as HIV use to convert their RNA into DNA in the infected cell.

1998 Infliximab

The anti-tumour necrosis factor blocker was introduced for the treatment of the autoimmune disease rheumatoid arthritis, but is now used in managing a much wider range of conditions.

2007 Sitagliptin

Merck launches the first of an expected series of type 2 diabetes drugs aimed at gut hormones.

Early 80s Aciclovir

The antiviral was the first of a series of compounds that interfere with viral replication.

Late 80s Simvastatin

The HMG-CoA reductase inhibitor simvastatin launched by Merck under the brand name Zocor.

2006 Varenicline

Marketed as Champix in the UK, varenicline is a nicotinic receptor partial agonist that reduces smokers' cravings for nicotine, thus helping to wean them off tobacco.

2009 Liraglutide

The latest of a series of ground-breaking drugs aimed at gut enzymes, Novo Nordisk's liraglutide for diabetes is a highly effective human glucagon-like peptide that can be injected at any time of day.

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C+D in association with PSNC the University of Greenwich and the Medway School of Pharmacy University of Kent

Pharmacy's privacy and professionalism is perfect for sales of incontinence products – so why is it losing market share to the supermarkets? **Sasa Jankovic** reveals how to reverse the trend

Gain confidence in incontinence

Urinary incontinence affects more than six million people in the UK, with estimates of up to one in four women over 35 and over three million men experiencing difficulties with bladder control.

Historically, 75 per cent of all incontinence products were sourced through institutions but, with NHS budgets being squeezed by other ailments, consumers are now having to rely more and more on the retail market. According to Lynne Henshaw, Numark's director of trade marketing, feminine hygiene is a category showing decline but "the hero within this category is incontinence products, which are showing growth".

And this is a prime opportunity for community pharmacy expertise. Data specialist Euromonitor is predicting strong sales in the adult incontinence category, which grew by almost 14 per cent in 2008. As well as continued product innovation, manufacturers are focusing firmly on repositioning incontinence by emphasising that it is a natural byproduct of ageing and childbirth rather than an embarrassing medical problem.

Recent product innovations in the sector have focused on creating more specialised products – such as gender-specific ranges – while also increasing comfort and protection through thinner yet more absorbent materials.

Major manufacturers have also launched campaigns aimed at educating consumers about the condition and lessening the stigma attached to it. In a bid to add weight to these campaigns, they are teaming up with incontinence charities and organisations to launch co-branded websites that allow the consumer to seek advice on the condition without the embarrassment of face-to-face contact.

Procter & Gamble used this approach in its UK and Ireland Always Envive Sense & Sensitivity campaign in March (www.alwaysenvive.co.uk), with the backing of Wellbeing of Women, a UK charity dedicated to solving women's health problems. Fronted by Ulrika Jonsson – who had herself admitted to suffering from incontinence after the birth of her children – the campaign aimed to break the taboo of incontinence and encourage women to get help.

According to Numark figures, pads are the biggest sellers, accounting for 80 per cent of all incontinence retail sales. But pant sales have been

> WE SHOULD BE CAPITALISING ON THE GROWTH OF INCONTINENCE SALES BEFORE GROCERS DO. IF WE'RE NOT CAREFUL WE WILL LOSE THIS BUSINESS

growing significantly faster over the past few years and are a major part of pharmacy incontinence sales, accounting for 30 per cent. Says Ms Henshaw: "We should be capitalising on this growth before grocers do. Soon enough suppliers will be talking to grocers about the fantastic growth of pants within pharmacy, and if we're not careful we will lose this business."

Hit the target

Pharmacy lost 1 per cent of its market value share to the supermarkets last year, according to data from IRI. And with purchasers of continence products not always being the end-user themselves, pharmacy must build on its reputation for knowledgeable advice to reach more of this category's target audience.

"I think patients probably split into two groups," says Helen Groves, Numark's own-brand controller. "There are those who go to pharmacy for advice and to get products there, and another group who go to supermarkets and buy products, but not necessarily the most suitable product for them. Of course, the risk with the first group is that they migrate to supermarkets as they get more confident in what they need and also to get better prices."

So how can pharmacies set themselves apart from other retailers in selling the category? Numark's merchandising manager Emma Charlesworth believes the way for community pharmacy to gain ground from the supermarkets is by helping customers choose the right product.

"Many people use the wrong product to cope with bladder weakness, resorting to feminine sanitary products, which are simply not designed to cope with urine," she advises.

"Ensuring that incontinence products are merchandised above these lines will encourage them to trade into the most appropriate product for their needs. The key to effectively merchandising products is ensuring that the appropriate incontinence products are quickly and easily located so the customer feels at ease when buying."

Customers also need tact, good advice and understanding to help them choose the correct product according to the degree of bladder problem and lifestyle. Another way to encourage this is to have information leaflets near the incontinence

Incontinence concerns: the vital stats

33%
of women over 30 affected by incontinence

53%
of affected women unwilling to discuss it

40%
of affected women have never sought advice from a health professional

29%
of affected women believe discussing incontinence with a sympathetic listener would help them feel more normal

60%
of affected women think incontinence ages them in the eyes of others

53%
of affected women say incontinence has caused loss of confidence

10%
of affected women say incontinence has made them feel depressed

17%
of affected women fear incontinence will change others' good opinions of them

33%
of affected women say their social life has suffered

Source: Always Envive, 2009

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APOTEX UK LTD
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The UK incontinence pads market

The value

£64 million

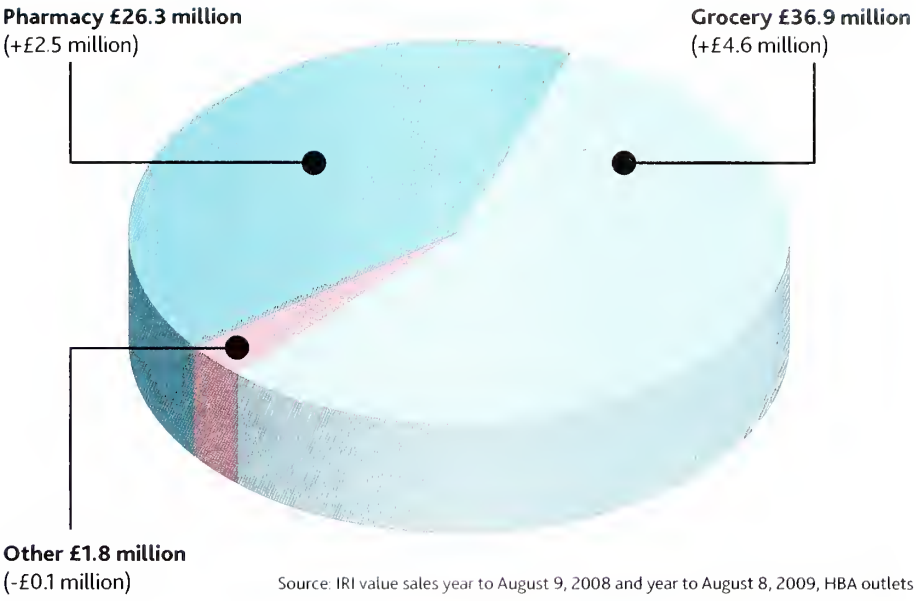
The growth

12.3%

Top sellers

1. Tena
2. Always Envive
3. Depend
4. Poise
5. Contisure
6. Alvita
7. Hartmann
8. Conveen
9. Kanga
10. Molicare Plus

Pharmacy v grocery



Source: IRI value sales year to August 9, 2008 and year to August 8, 2009, HBA outlets

products (and perhaps by feminine hygiene) and in the waiting area near the dispensary.

But there's more to creating a competitive edge than good advice and considered merchandising. For pharmacy to really succeed it needs a third driver for sales, according to Joanna Dee, P&G's UK pharmacy manager, who says: "Promotions need to be highlighted along with point of sale to create 'theatre' to drive impulse sales."

The products which will drive growth, and the ones to stock right now, are those for light incontinence. According to Euromonitor, although moderate/heavy incontinence products currently account for 52 per cent of the total sector, it was light products that posted the strongest growth in 2008, of 16 per cent, and the trend is set to continue.

Own brands, too, provide particular opportunities for pharmacy over other retailers, but don't go overboard, as Ms Groves of Numark says: "Stock only one own brand range and make it one that isn't readily available in every pharmacy, to encourage customers to return to you."

Tena training for pharmacists and staff

SCA Personal Care's Tena brand runs a pharmacy training initiative to help pharmacy staff break down the taboo associated with bladder weakness. The programme includes an NPA-endorsed training pack accredited for pharmacists' CPD, a further series of learning modules and nationwide face-to-face training for pharmacy staff. For more information, call the Tena Pharmacy Helpline on 0870 333 0874.

How incontinence investment worked for me

Christine Tomlinson: provide continuity of stock that meets the demands of customers

Numark member Christine Tomlinson opened Nash Pharmacy in Bolton in 1988. At that time, incontinence was a category that sold very little. Now, Nash Pharmacy has 30ft of space allocated to it. "Clearly it makes sense to stock according to the demands of my customers," says Ms Tomlinson. "They want continuity of product, especially if they are older or sending someone else to get it for them, so it's essential they know I can get the same brands. We also deliver, as some of these are very bulky products, and, again, this helps to keep custom."

There is also an opportunity for link sales such as: bed pads, which can be used in wheelchairs as well as beds; plastic mattress covers; plastic pants; and bed pans. "And I make sure I stock male and female products, which some shops forget," Ms Tomlinson adds. "It's important with these products that people can see where they are as they might not want to ask for them."

Ms Tomlinson believes pharmacy can gain the edge on the supermarkets by stocking a broader range of products and providing advice that they can't get elsewhere.

"People appreciate that I and many of my staff have been in this pharmacy a long time," she says, "so we can provide a very personal service. It is our point of differentiation."

Jobs

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Booking and copy date
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subject to availability

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London SE1 9UY

What's it like to be...

...a helpline pharmacist? NHS 24 advisor Lesley Clark reveals all

Lesley Clark: "I never know what the next call is going to bring"

There are never two days the same in my job as a pharmacy advisor at NHS 24 – I really enjoy the variety it involves. I am responsible for responding to medicine-related calls to NHS 24, Scotland's confidential telephone health advice and information service.

People phone into the service with all kinds of pharmacy-related enquiries. For example, they may have questions about what medicines to take for minor ailments, or they may be worried about having accidentally taken extra doses of their medication. I also support NHS 24 nurses with any queries they may have about medication and the suitability and availability of OTC drugs.

There are a variety of outcomes for people who phone NHS 24. I can offer them simple self-care advice or I can refer them on to a community pharmacist to receive any necessary treatment.

Community pharmacists in Scotland have various tools available to help them provide care for patients in the out-of-hours period. These include a patient group direction (PGD) that enables supplies of repeat medication when patients have run out and also the direct referral process, whereby pharmacists can phone out-of-hours GP services directly to discuss care of patients or to arrange appointments.

Or, depending on their minor ailment, I can refer the patient on to another out-of-hours service within their local health board – for example, an out-of-hours GP. It depends on the call and the assessment that is carried out.

Getting the opportunity to speak to different patients is, without a doubt, my favourite part of the job. I never know what the next call is going to bring and I especially like those enquiries that are a bit unusual and get the brain ticking over. I thrive on these and I feel a real sense of achievement in finding the right solution for the patient.

My role also involves training new nurses and call handlers about the services available from community pharmacists, as they are valuable healthcare professionals to whom NHS 24 refers many patients.

I joined NHS 24 four years ago as part of the first intake of pharmacists to the service. Working part-time during the out-of-hours period (in the evenings and weekends) fits in well with my family life as I have two young sons. It was one of the things that first attracted me to the job.

Working during the out-of-hours period does have its drawbacks and it is sometimes tough having to go out in the evening after looking after my sons all day. I do enjoy the change of scene to being at home though – the advantages far outweigh the disadvantages.

In any spare time that I do have – and it is difficult with two young children – I like to play the clarinet and saxophone. I play for my local church and I enjoy it because I have a life outside work and home.

I decided I wanted to become a pharmacist in my fourth year at high school. The rest of my family are teachers but I had a real interest in science and decided I wanted to do something different. I also liked the fact that there were different options available to me in this career.

Since I qualified as a pharmacist in 2001, I have worked in hospitals in London and as a community pharmacist in Aberdeen. Working at NHS 24 is completely different. The fact that you are not able to see your patients makes it more challenging. It is important to get as many details and descriptions about their symptoms because you can't see for yourself.

In the past four years the service has become busier. I think this is due to greater awareness among members of the public, but also among my health service colleagues.

I am really happy in my current role, which I also combine with a job working one day a week at a local GP surgery. I think I have achieved a good balance in my career and home life and I get a real sense of satisfaction in helping people.

Career tip of the week

Your questions answered

Q Two of my staff members have fallen out and it's affecting their work as well as team morale. How should I tackle the problem?

Tracy Murray, HR operations business partner at The Co-operative Pharmacy (pictured below), responds:

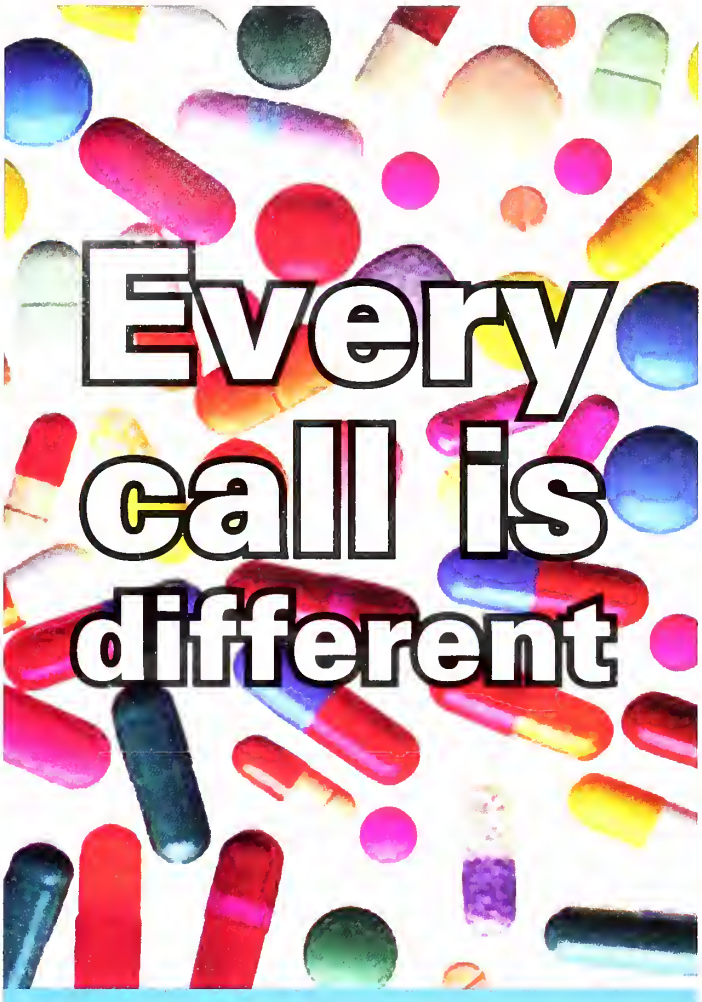
A The key to managing conflict is to deal with the situation as soon as you become aware of it. This way you can hopefully resolve any issues before they escalate.

Start by sitting down with each employee individually to try to identify what the problem is. It is very important to gather their individual perspectives on the situation. Ensure that each employee understands what behaviour is expected of them; they may not be friends, but they must be professional and courteous and fulfil their duties. You should also highlight the impact that their behaviour is having on the rest of the team, and the consequences of not performing.

The next step is to get the two parties together to try to reach a solution – they may agree to do this themselves, or you may have to act as a facilitator to support this. It is important that you don't take sides during this process.

In the majority of cases you will be able to reach a resolution informally. However, where this is not possible, you may have to resort to taking formal disciplinary action where behaviour or performance becomes unacceptable.

Once the issue has been resolved, by informal or formal means, then it is important to follow up with the individuals concerned to see how things are going, and to ensure that there have been no further issues.



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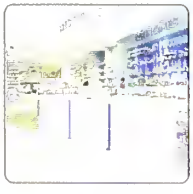

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Postscript...

Mike Hewitson's diary of a new pharmacy owner

Fully operational for flu

Beaminster Pharmacy has stepped onto the front line of the fight against swine flu as we are now a fully operational antiviral collection point. I had always been in favour of becoming a collection point, not because it is another source of income but because I felt the people of the town were being a little ignored by the powers that be.

One in six people in our town has no access to a car, according to the most up to date government statistics. A trek across the county to access another collection point was in my view discriminatory. Finally, the call has come, and I am able to perform a useful function in the pandemic, which for me has yielded more paper than patients.

On our first day as a live collection point we were asked by the local surgery to supply antivirals for a one-year-old child. The pharmacy was just about to close but I agreed to stay open. Fortunately the supply was a relatively straightforward process, which was a relief because mum was anxious and I felt that my time was best spent advising her about controlling her child's temperature and other symptoms.

We are told that the Department of Health is planning for a peak of cases in October; we can only hope that we are now ready to deal with any influx of cases, but for the moment it is the calm before the storm.

> FINALLY, THE CALL HAS COME AND I AM ABLE TO PERFORM A USEFUL FUNCTION IN THE PANDEMIC, WHICH FOR ME HAS YIELDED MORE PAPER THAN PATIENTS

Raiders of the lost archives

C+D 1859-2009 Celebrating 150 years in pharmacy

C+D went a bit off tangent in July 1860, when it decided to focus on news stories that had nothing to do with the sector at all.

First up in the 'Mirror of the Month' section was the Victorian equivalent of tabloid gossip: some bounder had been stealing candles.

"It is said the brother of a nobleman well known on the turf has been expelled from a London club for stealing candles," reported C+D, shaking with Victorian righteousness at the outrage. "The noble delinquent is, we believe, in the receipt of £20,000 a-year."

Leaving the reader hanging with this cryptic statement, the column then decided to discuss a subject of more interest to readers: being eaten by a tiger.

"Since January, 1859," said C+D, "1,500 Chinese have been carried off by tigers in Johore, at the end of the Malacca peninsula. It is now difficult to induce Coolies to work in Johore."

Postscript doesn't blame them. But we're still not sure what a Malaysian tiger rampage, or a toff candle-pincher, has to do with owning a pharmacy...

Get involved in C+D's birthday celebrations www.chemistanddruggist.co.uk/birthday

A true war hero and pharmacy professional

Postscript is sad to report the death of a true hero of the profession: a pharmacist who not only kept on dispensing during the second world war but went on to be recognised for his bravery.

Fernleigh Morcom qualified as a pharmacist in 1939, starting his trade shortly after war broke out. His Plymouth pharmacy was bombed three times in 1941, but each time he relocated and kept serving customers. Then, in 1942, he was conscripted into the army.

Now a major, Mr Morcom was mentioned in dispatches for bravery during the fighting in North Africa, while under General Montgomery. He was held in such regard that when the war ended he drove Monty's car back to Blighty.

Mr Morcom – who never used his military title – died on August 10 aged 93.

Postscript salutes him, and every other pharmacist who fought during the second world war.

Ol' Blue Eyes played his part

Postscript was this week stunned to discover that one of the greatest stars of the last century was a pharmacist. Well, a pretend pharmacist, at least – it turns out that none other than Ol' Blue Eyes, Mr Frank Sinatra, played a pharmacist in an old war movie.

Sadly not containing any scenes of Mr Sinatra crooning as he filled the odd script, None But the Brave is the story of a group of American and Japanese soldiers marooned together on a Pacific island. Lacking a doctor, in one memorable scene chief pharmacist Frankie gets out his scalpel and, with the aid of a bottle of whisky, amputates an injured soldier's leg.

The movie was Frank's only foray into the director's chair. So, not only did he choose to be a pharmacist, but more, much more than this, he did it his way.

Can you think of stars with pharmacy links?

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